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No. 88-1503

IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

NANCY BETH CRUZAN, by her parents and co-guardians, LESTER L. and JOYCE CRUZAN,
Petitioners,
v.

ROBERT HARMON, Director of the Missouri Department of Health, and DONALD LAMKINS, Administrator of the Missouri Rehabilitation Center at Mount Vernon,
Respondents,
v.

THAD C. MCCANSE,
Guardian Ad Litem,
Respondent.

On Writ of Certiorari to the Supreme Court of Missouri

BRIEF AMICUS CURIAE OF THE SOCIETY FOR THE RIGHT TO DIE, INC. IN SUPPORT OF PETITIONERS

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BRIEF AMICUS CURIAE OF THE SOCIETY FOR THE RIGHT TO DIE, INC. IN SUPPORT OF PETITIONERS

INTEREST OF AMICUS

The Society for the Right to Die, Inc. ("The Society") is a national not-for-profit educational organization founded in 1938.* Its focus is advocacy of the individual's right to control medical treatment, including the right to choose to reject life-sustaining treatment and avoid the futile prolongation of the dying process.

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* This brief has been filed on consent of the parties. The letter of consent is filed with the Clerk of the Court.

The Society, with over 150,000 members and supporters nationwide, is probably the most consulted single source of information in this country on all aspects of the right to refuse medical treatment. It is involved in an extensive educational effort with the legal, medical, ethical, and religious communities, as well as the general public, with regard to patients' rights, living wills and medical decisionmaking procedures. Forty-two states and the District of Columbia now have either natural death legislation or statutes authorizing decisionmaking by an appointed surrogate. The Society distributes living wills and medical durable power of attorney forms throughout the country, free of charge. In 1988 alone, as a result of requests from the public, the Society distributed nearly half a million living wills and related documents and counselled more than 150 patients and families who were seeking advice about actual situations in which withholding or withdrawing life-sustaining medical treatment was an issue.

INTRODUCTION AND SUMMARY OF ARGUMENT

Nancy Cruzan is not representative of most dying patients, but her plight raises many of the issues that arise in other cases where life-sustaining treatment is sought to be withheld or withdrawn. Approximately two million Americans die every year. Eighty percent of those deaths take place in a hospital or nursing home, and nearly all of those deaths involve a decision by someone to do or *not* to do something which could, for some time, avert the moment of that death and prolong the dying process.[1] ". . . [T]he timing of death—once a matter of fate—is now a matter of human choice." U.S. CONGRESS: OFFICE OF TECHNOLOGY ASSESSMENT, LIFE SUSTAINING TECHNOLOGIES AND THE ELDERLY 41 (1987).

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[1] PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE SUSTAINING TREATMENT: A REPORT OF THE ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS 16-18 (1983).

Nancy Cruzan's case presents a dramatic and poignant example of the complex societal issue which many families now face. Due to Nancy's youth and her condition, the use of artificial life support (in her case, tube feeding) can prolong her dying process long enough for her case to proceed through the appellate courts and well beyond. Nancy's youth has two other effects which sharpen the issue before this Court. It has permitted her to stabilize into a condition that will not improve, but in which she could be maintained for thirty years. In addition, since her accident occurred when she was only 25 years old, her statements about death and her personal preferences about life-sustaining treatment were not as extensive as they might have been if she were older when the accident occurred.

Who is to decide about the application of life sustaining treatment? Who speaks for Nancy Cruzan? Her close family, whose loving motives were acknowledged by the Missouri Supreme Court, know she would not want to be sustained in this condition. The Missouri decision, however, stripped them of any input into their daughter's care and condemned them to a thirty year bedside vigil in order to protect unnamed and unspecified others.

Nancy Cruzan has a right to an individualized medical decision consistent with her constitutional rights to self-determination, privacy and liberty. These rights were not obliterated when the emergency medical team "saved" her at the scene of the automobile accident.

While other courts have grappled with the question of standards for deciding medical care for incompetent patients, no other court has renounced individuality by handing over the power to decide to the state. As we demonstrate, by a bare majority, the Missouri Supreme Court crossed the constitutional line. It did not merely regulate medical decisionmaking, it forbade a particular medical decision, in violation of Nancy Cruzan's constitutional rights.

ARGUMENT

I. NANCY CRUZAN HAS A CONSTITUTIONAL RIGHT TO AN INDIVIDUALIZED DECISION ABOUT HER MEDICAL TREATMENT

The medical situation which confronts Nancy Cruzan (long term maintenance in a permanently unconscious state) is new, but the rights sought to be enforced on her behalf are long-standing and fundamental. The Supreme Court's articulation of the right of self-determination is as compelling now as it was in 1891:

> No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference by others, unless by clear and unquestionable authority of law.

Union Pacific Railway Co. v. Botsford, 141 U.S. 250, 251 (1891). When the government compels medical treatment, it violates "the most comprehensive of rights and the right most valued by civilized men," which is the "right to be let alone." *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

The right to control one's medical course and be free of unwanted treatment is a fundamental personal right " 'implicit in the concept of ordered liberty,' " which is "deeply rooted in this Nation's history and tradition." *Bowers v. Hardwick*, 478 U.S. 186, 191-192 (1986), quoting *Palko v. Connecticut*, 302 U.S. 319 (1937) and *Moore v. City of East Cleveland*, 431 U.S. 494 (1977). As stated by the Washington Supreme Court:

> The decision by the incurably ill to forego medical treatment and allow the natural processes of death to follow their inevitable course is so manifestly a "fundamental" decision in their lives, that it is virtually inconceivable that the right to privacy would not apply to it.

In re Colyer, 99 Wash. 2d 114, 120, 660 P.2d 738, 742 (1983), quoting *In re Eichner*, 73 A.D.2d 431, 459, 426 N.Y.S.2d 517 (1980), *aff'd sub nom. In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

The federal constitutional dimension of the right to refuse medical treatment has been recognized by numerous state and federal courts.[2]

At issue in this case is whether the government can compel medical treatment in violation of two interests long recognized as worthy of constitutional protection. The first is the interest in the protection of the bodily integrity of the individual, of which it has been said that forced surgery "damages the individual's sense of personal privacy and security." *Winston v. Lee*, 470 U.S. 753, 762 (1985); see also, *Rochin v. California*, 342 U.S. 165, 174 (1952) (forced stomach pumping "offensive to human dignity"). The second unconstitutional intrusion arises as a result of Nancy's incompetence, and is the substitution of the state as decisionmaker for the patient

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[2] See, e.g., *McConnell v. Beverly Enterprises*, 209 Conn. 692, 701, 553 A.2d 596, 600 (1989); *Gray v. Romeo*, 697 F. Supp. 580, 585 (D.R.I. 1988); *Rasmussen v. Fleming*, 154 Ariz. 207, 214, 741 P.2d 674, 682 (1987); *In re Farrell*, 108 N.J. 335, 348, 529 A.2d 404, 410 (1987); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 430, 497 N.E.2d 626, 633 (1986); *Bartling v. Superior Court (Glendale Adventist Medical Center)*, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220, 225 (Ct. App. 1984); *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809, 814 (Ct. Com. Pl. 1980); *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*, 452 So. 2d 921, 924 (Fla. 1984); *In re L.H.R.*, 253 Ga. 439, 446, 321 S.E.2d 716, 722 (1984); *In re Colyer*, 99 Wash. 2d 114, 120, 660 P.2d 738, 742 (1983), *modified, In re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *In re Severns*, 425 A.2d 156, 158 (Del. Ch. 1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 739, 370 N.E.2d 417, 424 (1977); *In re Quinlan*, 70 N.J. 10, 38-42, 355 A.2d 647, 662-664, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976), *overruled in part, In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

who can no longer express her own wishes, entering into the usually sacrosanct realm of family privacy.

This Court recognizes the limits of governmental intrusion in basic areas of individual liberty, family privacy and bodily integrity in the context of forced surgical examination, *Union Pacific Railway v. Botsford*, 141 U.S. 250, 251 (1891); forced stomach pumping, *Rochin v. California*, 342 U.S. 165, 174 (1952); marriage, *Loving v. Virginia*, 388 U.S. 1 (1967); contraception, *Griswold v. Connecticut*, 381 U.S. 479 (1965), *Eisenstadt v. Baird*, 405 U.S. 438 (1972); procreation, *Skinner v. Oklahoma*, 316 U.S. 535, 541-543 (1942); child rearing and education, *Wisconsin v. Yoder*, 406 U.S. 205 (1972), *Pierce v. Society of Sisters*, 768 U.S. 570 (1925) and *Meyer v. Nebraska*, 262 U.S. 390 (1923); and family relationships, *Prince v. Massachusetts*, 321 U.S. 158 (1944). Mandating a particular form of medical treatment to an incompetent patient over the objections of her family is a similarly offensive and potentially limitless exercise of governmental power.

Our choices about how to deal with incurable and irreversible sickness are as personal and fundamental as our decisions about how to rear children or who to marry. Decisions to forgo medical treatment can be premised on such varying rationales as a religious belief in spiritual life after death, a personal desire to spare one's family prolonged agony, an abhorrence of dependence or helplessness or a specific choice to leave one's money for the education of grandchildren, rather than the profits of a nursing home. The protection of these intensely personal, ethical and religious values, usually formed and fostered within the family, is firmly embedded within our constitutional values. As recently stated:

> [These cases finding a protected liberty interest] rest . . . upon the historic respect—indeed, sanctity would not be too strong a term—traditionally accorded to the relationships that develop within the unitary family.

Michael H. v. Gerald D., 109 S. Ct. 2333, 2343 (1989). This unbroken line of cases beginning with *Meyer v. Nebraska*, 762 U.S. 390, 399-401 (1923) and *Pierce v. Society of Sisters*, 268 U.S. 510, 534-535 (1925), consistently respect a "private realm of family life which the state cannot enter." *Moore v. City of East Cleveland*, 431 U.S. 494, 499 (1977).

Nancy Cruzan's incompetence does not render her any less of a human being entitled to an individualized decision about her care, made by the people who knew her and love her. As every other court has held, the right to refuse treatment is not lost merely because the "noncognitive and vegetative condition of the patient prevents a conscious exercise of the choice to refuse further extraordinary treatment." *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*, 452 So. 2d 921, 924 (Fla. 1984). See e.g., *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977). The Missouri Supreme Court, by ordering unlimited treatment for all incompetent patients, refused to recognize that patients are individuals with a history and a value system of their own:

> Medical choices are private, regardless of whether a patient is able to make them personally or must rely on a surrogate. They are not to be decided by societal standards of reasonableness or normalcy. Rather it is the patient's preferences—formed by his or her unique personal experiences—that should control.

In re Peter, 108 N.J. 365, 373, 529 A.2d 419, 423 (1987).

The right to a personalized decision, carried out by one's family or loved ones, is supported both by medical ethics and public opinion. The medical establishment, represented by the American Medical Association, the American Academy of Neurology and the American College of Physicians, among others, speaks with one voice on this issue; the amicus briefs filed in this case are a demonstration of that unanimity.

An overwhelming majority of citizens similarly believe strongly that the right to make medical decisions includes a right to forgo life sustaining treatment and that choices about these issues should remain within the family. A 1986 American Medical Association poll indicated that 73% of the 1,510 respondents favored "withdrawing life support systems, including food and water, from hopelessly ill or irreversibly comatose patients if they or their family request it." American Medical Association, "Public Opinion on Health Care Issues—1986," Chicago, Ill. (1986). A teleconference poll moderated by Ted Koppel revealed that 79% of those polled believe that quality of life determinations should be considered in the decision of whether to use life-sustaining technology, and 70% believe that the immediate family, not the courts, should decide in the case of an incompetent patient. New York Times, Dec. 2, 1986. A very recent survey conducted by the Colorado Graduate School of Public Affairs revealed that 85% of those surveyed would not want to have their life maintained with artificial feedings if they became permanently unconscious and could not eat normally. Fort Collins Coloradoan, Sept. 29, 1988, at 1. See, also, *In re Jobes*, 108 N.J. 394, 418, n. 11, 529 A.2d 434, 446, n. 11 (1987).

II. THE STATES HAVE PROTECTED PATIENT CHOICE THROUGH STATUTES AND COURT DECISIONS

In contrast to Missouri's foreclosure of patient choice, other states have been extremely protective of the individual's right to die without unwanted medical treatment. Forty states and the District of Columbia have living will laws, which permit an individual to execute a document to express his or her own wishes regarding death-prolonging treatment.[3]

[3] States with "Living Will" (also called "natural death," "right to die," or "rights of the terminally ill") statutes are: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut,

Such statutes typically define the conditions under which the document becomes effective, which are usually that the patient must be in a "terminal condition." The definition of "terminal" varies, sometimes requiring "imminent" death, with or without life-sustaining treatment, and sometimes including the "permanently unconscious." These statutes either list the medical procedures that fall within the definition of "life-prolonging" treatments or provide general definitions such as "any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying." The legislation frequently includes specific witnessing procedures, and other execution requirements. As a practical matter, the inclusion of clear immunity from civil or criminal liability for the health care providers who honor the documents is a feature that adds immeasurably to acceptance of the documents by the health care community. See generally, Cohen, *Living Wills and Health-Care Proxies*, in MURPHY'S WILL CLAUSES—ANNOTATIONS AND FORMS (M. Bender ed. 1988).

An alternative method of statutory protection for the right to refuse treatment is the creation of a durable power of attorney for health care decisions. 17 jurisdictions allow the appointment of an individual to make decisions regarding life-sustaining treatment upon the incompetence of the principal, either by an explicit statute or by judicial interpretation.[4] The statutes range from

Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming. See fns. 12-15 for full citations.

[4] Arizona, Ariz. Rev. Stat. Ann. §§ 14-5501, 14-5502 (1975), as interpreted by *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987); California, Cal. Civ. Code §§ 2430, et seq. (West Supp. 1989); Colorado, Colo. Rev. Stat. § 15-14-501 (1975), as interpreted by *In re Rodas*, No. 86PR139 (Colo. Dist. Ct. Mesa County Jan. 22,

providing a total grant of authority to the agent, to permitting only a circumscribed number of decisions. Use of both living wills and durable powers of attorney for health care, an option available in many states, allows an individual to make known his or her own wishes regarding artificial life support and permits the individual to indicate who would be best suited to communicate those treatment preferences to the health care providers, interpreting and supplementing the instructions if necessary.

While organizations such as the Society for the Right to Die advocate advance planning to ensure respect of individual treatment choices, it is common wisdom that people do not like to contemplate their own death. Meyers, *Medico-Legal Implications of Death and Dying* 277 (1981). Many people delay writing a property will, and die intestate, so it is not surprising that the available data indicates that a relatively small number of people (9%) execute advance directives or living wills and formally address the more emotional decision about how they would wish treatment decisions that precede their death to be handled, when they can no longer speak for

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1987, *as modified*, April 3, 1987) (Buss, J.); District of Columbia, D.C. Code Ann., tit. 21, ch. 22 (1988); Hawaii, Hawaii Rev. Stat., § 560:5-501 and § 327D-26 (Supp. 1987); Illinois, Ill. Ann. Stat. ch. 110 1/2, § 804-1 (1988); Iowa, Iowa Code Ann. §§ 633.705 and 144.A.7(1) (Supp. 1988); Maine, Me. Rev. Stat. Ann. tit. 18-A, § 5-501 (Supp. 1987); Maryland, Md. Est. & Trusts Code Ann. § 13-601 and Md. Health General Code Ann. § 20-107(d) (Supp. 1987); Nevada, Nev. Rev. Stat. § 449.80 (Supp. 1987); New Jersey, N.J. Stat. Ann. §§ 46:2B-8, 2B-9 (West Supp. 1988), as interpreted by *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987); New York, N.Y. Gen. Act, Oblig. Law §§ 5-1501 (McKinney Supp. 1988), as interpreted by *In re Westchester County Med. Center* (O'Connor), 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988); Ohio, Ohio Rev. Code § 1337.11 (1989); Oregon, Power of Attorney for Health Care Act, S.523, signed by Governor, 8/21/89, effective 10/3/89: Rhode Island, R.I. Gen. Laws § 23-4.10-2 (Supp. 1987); Texas, "An Act relating to Durable Power of Attorney for Health Care," signed by Governor and effective 6/14/89; and Vermont, Vt. Stat. Ann. tit. 14, §§ 3451-67 (Supp. 1988).

themselves. Emanuel & Emanuel, *The Medical Directive: A New Comprehensive Advance Care Document*, 261 J. A.M.A. 3288 (1989).

In response to the fact that most people do not have living wills, but will nonetheless be the subject of medical decisions when incompetent, twelve states have enacted statutory procedures which, like the laws of intestacy, fill the gap between the theory of advance planning and the everyday reality of preferring to avoid thoughts of death.[5]

Those states have enacted statutory surrogate decision-making provisions which authorize certain individuals to make treatment decisions on behalf of incompetent patients. The list of individuals, in an order of priority, reflects a legislative determination of the surrogates most people would choose, and guides the health care team to the family or others who should be consulted on questions of life sustaining treatment. Much like the law of disposition of property, those individuals who wish to vary the legislative presumption, can leave their own instructions by executing a living will or a durable power of attorney for health care.

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[5] Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, Ark. Stat. Ann. § 20-17-214 (1987); Connecticut Removal of Life Support Systems Act, Conn. General Stat. § 19a-571 (West Supp. 1989); Florida Life Prolonging Procedure Act, Fla. Stat. Ann. § 765.07 (1986); Iowa Life Sustaining Procedures Act, Iowa Code Ann. § 144A.7 (West Supp. 1986); Louisiana Declarations Concerning Life-Sustaining Procedures Act, La. Rev. Stat. Ann. § 40:1299.58.5 (West Supp. 1989); New Mexico Right to Die Act, N.M. Stat. Ann. § 24-7-8.1 (1986); North Carolina Right to Natural Death Act, N.C. Gen. Stat. Ann. § 90-322 (1985); Oregon Rights with Respect to Terminal Illness Act, Or. Rev. Stat. § 97.083 (1985); Texas Natural Death Act, Tex. Rev. Civ. Stat. Ann. art. 4590h-Section 4C (Vernon Supp. 1989); Utah Personal Choice and Living Will Act, Utah Code Ann. § 75-2-1105(2) (1989); Virginia Natural Death Act, Va. Code § 54:1-2986 (1988); District of Columbia, Health Care Decisions Act of 1988, tit. 21, ch. 22 Section 11 (1988); See also, Uniform Rights of the Terminally Ill Act, Section 7, 9A U.L.A. 456 (as amended, 1989).

State courts (but for Missouri) have supplemented these statutory rights by developing a uniform body of case law, which relies on common law, federal and/or state constitutional principles to endorse various forms of advocacy by family members on behalf of incompetent patients. While living wills and durable powers of attorney provide mechanisms for the simpler and less controversial decisions, the courts have vigorously protected patients' rights to decline artificial life support in circumstances outside the statutory schemes.

Twenty-six jurisdictions have case law finding that the state had no interest which would outweigh an individual's right to forgo artificial life support.[6] Depending on

[6] Since the 1976 *Quinlan* case, twenty-six jurisdictions have issued "right-to-die" rulings authorizing the termination of life support for patients in a variety of circumstances. See, e.g., Arizona: *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987); California: *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (Cal. Ct. App. 1988), *review denied* (Cal. July 28, 1988), *cert. denied*, 109 S. Ct. 399 (1988); Colorado: *In re Rodas*, No. 86PR139 (Colo. Dist. Ct. Mesa County Jan. 22, 1987, *as modified*, April 3, 1987) (Buss, J.); Connecticut: *McConnell v. Beverly Enterprises*, 209 Conn. 692, 553 A.2d 596 (1989); Delaware: *In re Severns*, 425 A.2d 156 (Del. Ch. 1980); District of Columbia: *Tune v. Walter Reed Army Medical Hospital*, 602 F. Supp. 1452 (D.D.C. 1985); Florida: *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*, 452 So. 2d 921 (Fla. 1984); Georgia: *In re L.H.R.*, 253 Ga. 439, 321 S.E.2d 716 (1984); Hawaii: *Wilcox v. Hawaii*, Civ. No. 860116 (Hawaii Cir. Ct. 5th Cir. June 16, 1986); Iowa: *Morgan v. Olds*, 417 N.W.2d 232 (Iowa Ct. App. 1987); Louisiana: *In re PVW*, 424 So. 2d 1015 (La. 1982); Maine: *In re Gardner*, 534 A.2d 947 (Me. 1987); Massachusetts: *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986); Michigan: *In re Culham*, No. 87-340537-AZ (Mich. Cir. Ct. Oakland County Dec. 15, 1987) (Breck, J.); Minnesota: *In re Torres*, 357 N.W.2d 332 (Minn. 1984); New Jersey: *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987); New York: *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981); North Dakota: *In re Bayer*, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 11, and Dec. 11, 1987) (Riskedahl, J.); Ohio: *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (Ct. Com. Pl. 1980); Oregon: *Evans v. District Attorney of Douglas County*, No. E82-2173 (Ore. Cir. Ct. Douglas County Dec. 13, 1982); Pennsylvania: *In re Jane Doe*, 16 Phila. 229 (Pa. Ct. Com. Pl. 1987); Rhode Island: *Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988); Texas: *In re Guardianship Estate of Peterson*, No. E117,982 (Texas Dist. Ct. Jefferson County Aug. 4, 1983); Virginia: *Hazelton [sic] v. Powhatan Nursing Home, Inc.*, 6 Va. Cir. Ct. Op. 414 (Aspen 1987) (Va. Cir. Ct. Fairfax County 1986) (Sept. 2, 1986) (Fortkort, J.), *appeal denied*, Record No. 860814 (Va. Sept. 2, 1986); Washington: *In re Guardianship of Grant*, 109 Wash. 2d 545, 747 P.2d 445 (1987), *modified*, 757 P.2d 534 (1988); Wisconsin: *In re Guardianship of Welch*, No. 89GN30 (Wis. Cir. Ct. Eau Claire County June 21, 1989).

the state, this body of law is at varying stages of development. For example, New Jersey's Supreme Court has addressed decision-making for the competent, the permanently unconscious and the minimally conscious. It has developed a judicially mandated role for prognosis or ethics committees in hospitals, and for the State Ombudsman for nursing home residents over 60. See, *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976), *overruled in part, In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987); *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987); *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987).

An initial ruling in Massachusetts implying that court approval was needed for all refusal of life-support decisions was refined, so that court authorization is only required if the medical treatment proposed offers some hope of leading to a "remission of symptoms enabling a return towards a normal functioning integrated existence." *In re Dinnerstein*, 6 Mass. App. 466, 380 N.E.2d 134 (Ct. App. 1978), clarifying *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977). Other courts have clearly held that judicial approval is not required, absent some conflict between the interested parties. *Conservatorship of Draback*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (Cal. Ct. App. 1988), *review denied* (Cal. July 28, 1988), *cert. denied*, 109 S. Ct. 399 (1988); see also *In re Torres*,

357 N.W.2d 332 (Minn. 1984); *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

The state judicial, legislative and health care systems will continue to establish the procedural framework for exercising the right to forgo medical treatment. Workable procedures to address the use of medical technology for the hopelessly ill will consistently be refined. As the states seek to accommodate the interests of all concerned, most have been mindful of the spirit expressed by the Florida 2d District Court of Appeal when it established a process under which life support could be ended:

> [T]he remedy exists to fulfill a right of privacy. Thus, the procedures to invoke and enforce this right should be as private as the state's competing interests can permit for such a delicate decision. We obviously do a poor job of protecting the patient's right of privacy by discussing the details of her medical condition and the natuure of her family structure in a highly publicized decision which will be preserved for posterity.

In re Browning, 543 So. 2d 258, 268-269 (Fla. Dist. Ct. App.), *appeal filed*, Case No. 74,1747 (1989). The Missouri Supreme Court stands alone by providing no remedy at all, and dictating a result to patients, families and doctors.

This departure from national medical and legal standards raises the spectre of a new and macabre form of forum shopping—transferring patients across state lines so they will be allowed to die.

III. THE STATE'S LEGITIMATE INTEREST IN PREVENTING ABUSE CANNOT UNCONSTITUTIONALLY BURDEN THE RIGHT TO FORGO TREATMENT

The state's interest in protecting its citizens against harm or abuse does not permit defining those terms so as to result in unconstitutional limitations on the right to an individualized medical decision. Four state interests

were articulated in the case law early in its development and have been repeatedly recited: (1) the preservation of life; (2) the protection of third parties; (3) the prevention of suicide and (4) the protection of the ethical integrity of the medical profession. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728 741, 370 N.E.2d 417, 425 (1977).[7]

When it reversed the lower court decision, the Missouri Supreme Court relied on the state's interest in the preservation of life to override any privacy or liberty rights that Nancy Cruzan might have. By a 4-3 vote, it twisted the state's duty to *prevent* abuse and created a situation in which continued forced treatment constitutes a more egregious form of abuse, with no concomitant state justification or benefit.

The state should protect its citizenry from abuse by regulating the *way* decisions are made, but cannot demand that patients accept its view of what the appropriate medical decisions should be. Patients need protection from decisions made in ignorance or bad faith, but those pro-

[7] Since their initial articulation in 1977, considerable attention has been paid to the issue of withholding and withdrawing treatment, and these state interests are now not necessarily the best articulation of governmental concerns. National organizations such as the American Medical Association and the American Academy of Neurology have taken public policy stances that clarify their position only within the last few years. As previously noted, it is now clear that the ethical integrity of the medical profession is fostered by honoring patient's wishes to forgo treatment, and that it is ethically appropriate to withhold or withdraw tube feeding from the permanently unconscious, consistent with their own previously stated wishes or their family's request. See generally, Wanzer, et al,. *The Physician and the Hopelessly Ill Patient: A Second Look*, 320 New Eng. J. Med. 844 (1989). None of the other traditional state interests are implicated here. Nancy Cruzan has no dependents, so there are no third parties to be protected. Nor is the State's interest in the prevention of suicide an issue. As the courts have repeatedly held, forgoing life sustaining medical treatment cannot be considered suicide. See, *e.g.*, *In re Farrell*, 108 N.J. 335, 350, 529 A.2d 404, 411 (1987).

tections can be provided institutionally, with courts as a last resort. Areen, *The Legal Status of Consent Obtained from Families of Adult Patients to Withhold or Withdraw Treatment*, 258 J. A.M.A. 229, 234 (1987); Rhoden, *Litigating Life and Death*, 102 Harv. L. Rev. 375, 443-445 (1988). A rule of law which speaks to eliminating all potential abuses by requiring unwanted treatment unfairly burdens the vast majority of well-meaning families, and does not take into account the checks and balances within the medical world. Attending physicians are required to conform to nationally accepted ethical standards, institutional committees review cases, confirming opinions can be sought, and judicial review in cases of conflict is always a possibility. *In re Jobes*, 108 N.J. 394, 422-423, 529 A.2d 434, 448-449 (1987); Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*, 31-33 (1987); *In re Colyer*, 99 Wash. 2d 114, 127, 660 P.2d 738, 746 (1983).[8]

The Missouri Supreme Court did not merely regulate the decisionmaking process for Nancy Cruzan; it decided that Nancy Cruzan must accept treatment. To withstand constitutional scrutiny, a limitation on an individual's privacy or liberty rights must be "*necessary* to the achievement of a *compelling* state interest." *Eisenstadt v. Baird*, 405 U.S. 438, 447 n.7 (1972) (emphasis added). The Missouri Supreme Court's articulated interest in the "preservation of life" cannot mean that as a society, we must maintain all biological existence indefinitely. The Court purported to limit the rights of Nancy Cruzan to forgo treatment on three separate grounds: her condition, the treatment at issue, and the evidence of her wishes. None of these reasons meets the "compelling state interest" test, and each unduly burdens a fundamental right to self determination, privacy and liberty.

[8] One-half to three-quarters of all hospitals now have ethics committees, as do some nursing homes. U.S. CONGRESS: OFFICE OF TECHNOLOGY ASSESSMENT, LIFE SUSTAINING TECHNOLOGIES AND THE ELDERLY, 63 (1987).

By ordering treatment for Nancy Cruzan in contravention of her family's view of what her wishes would be, Missouri crossed the constitutional line which protects the citizenry from governmental interference in these extraordinarily personal and troubling dilemmas.

A. The Missouri Supreme Court Unconstitutionally Burdened the Right to Forgo Medical Treatment by Limiting the Exercise of the Right to Certain Medical Conditions

Nancy Cruzan lies in a persistent vegetative state, a condition which the Missouri Supreme Court found distinguished the rights at issue from those of competent patients or the terminally ill.[9]

No other court has taken the position that the state's interest in the preservation of life extends to the forced feeding of a patient in a persistent vegetative state. As the New Jersey Supreme Court stated, it is "difficult to conceive of a case in which the state could have an interest strong enough to subordinate a patient's right to choose not to be artificially sustained in a persistent vegetative state." *In re Peter*, 108 N.J. 365, 380, 529 A.2d 419, 427 (1987). While the state has a legitimate and important interest in protecting its most vulnerable and helpless citizens, "the greater risk of abuse lies in disregarding such specifically declared personal decisions and in imposing life-sustaining procedures upon the patient contrary to his express will." *In re Gardner*, 534 A.2d 947, 955 (Me. 1987). Any concept of the sanctity of life, and interest in the preservation of life, must also "en-

[9] The use of the term "terminally ill" is frequently and frustratingly inaccurate. The Missouri Supreme Court described Nancy Cruzan as not terminally ill, in contrast to Karen Quinlan and Brother Fox, the patient in *In re Eichner (In re Storar)*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981). *Cruzan v. Harmon*, 760 S.W.2d 408, 415 (1988), *cert. granted*, 109 S. Ct. 3240 (1989). In fact, all three were diagnosed as being in persistent vegetative states, which the American Academy of Neurology, the relevant authority, states does not constitute a terminal illness.

compass a recognition of an individual's right to avoid circumstances in which the individual himself would feel that efforts to sustain life demean or degrade his humanity." *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 434, 497 N.E.2d 626, 635 (1986).

The state's interest in the preservation of life cannot, however, permit the government to make determinations about what constitutes an acceptable quality of life for its citizens. As the New Jersey Supreme Court held:

> The privacy that we accord medical decisions does not vary with the patient's condition or prognosis. The patient's medical condition is generally relevant only to determine whether the patient is or is not competent, and if incompetent, how the patient, in view of that condition, would choose to treat it were she or he competent.

In re Peter, 108 N.J. 365, 373, 529 A.2d 419, 423 (1987); *see also, In re Conroy*, 98 N.J. 321, 355, 486 A.2d 1209, 1226 (1985). Even an excellent prognosis, albeit irrelevant for Nancy Cruzan, does not justify overriding a competent patient's desires. *Public Health Trust of Dade County v. Wons*, 541 So. 2d 96, 100 (Fla. 1989). Choices are for the patient, not the doctors or the state: "[I]f the patient's right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole." *In re Conroy*, 98 N.J. 321, 352-353, 486 A.2d 1209, 1225 (1987).

B. The Missouri Supreme Court Unconstitutionally Refused to Allow Patients the Right to Forgo Artificial Feeding

An attempt to justify burdening Nancy Cruzan's privacy and liberty interests by distinguishing between tube feeding and other forms of treatment, also will not withstand constitutional scrutiny. Feeding undeniably has special symbolic and emotional connotations, but subjective attitudes have no place in a debate about whether a person should be treated against her will:

> Analytically, artificial feeding by means of a nasogastric tube or intravenous infusion can be seen as equivalent to artificial breathing by means of a respirator. Both prolong life through mechanical means when the body is no longer able to perform a vital bodily function on its own.
>
> Furthermore, while nasogastric feeding and other medical procedures to ensure nutrition and hydration are usually well tolerated, they are not free from risks and burdens; they have complications that are sometimes serious and distressing to the patient.

In re Conroy, 98 N.J. 321, 373, 486 A.2d 1209, 1236 (1985) (citations omitted). Feeding tubes have been found by some states to be "intrusive treatment as a matter of law." *Brophy v. New England Sinai*, 398 Mass. 417, 435, 497 N.E.2d 626, 636 (1987).

Tube provision of feeding formula is acknowledged by the medical profession, and most courts, as a form of care that may be legally and ethically withdrawn if to do so is in accordance with the patient's wishes. With the exception of Missouri and a recent intermediate court decision in Ohio, every court to have considered the issue has held explicitly that tube feeding is medical treatment that may be withdrawn. *See e.g., Corbett v. D'Alessandro*, 487 So. 2d 368 (Fla. Dist. Ct. App.), *review denied*, 492 So. 2d 1331 (Fla. 1986); *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (Cal. Ct. App. 1988), *review denied* (Cal. July 28, 1988), *cert denied*, 109 S. Ct. 399 (1988); *McConnell v. Beverly Enterprises*, 209 Conn. 692, 553 A.2d 596 (1989); *In re Gardner*, 534 A.2d 947 (Me. 1987); *Delio v. Westchester County Medical Center*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987); *Brophy v. New England Sinai Hosp., Inc.*, 389 Mass. 417, 497 N.E.2d 626 (1986); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988).[10]

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[10] A Washington Supreme Court decision upholding the right to reject tube feeding was modified when one Justice changed her

The courts, holding that artificial feeding should be treated like other medical procedures, have relied on the wide range of medical and ethical authorities which also conclude that it is appropriate to withhold or withdraw artificially supplied nutrition and hydration, when to do so is consistent with the patient's wishes. *See, e.g.*, Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* 61 (1987); AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, WITHHOLDING OR WITHDRAWING LIFE-SUSTAINING MEDICAL TREATMENT, IN CURRENT OPINIONS OF THE COUNCIL OF ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION 12-13 (1986); PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS 90 (1983).[11]

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vote a year later. *In re Guardianship of Grant*, 109 Wash. 2d 545, 747 P.2d 445 (1987), *modified*, 757 P.2d 534 (1988). She joined a concurring opinion, which stated it was not necessary to reach the issue of whether artificial feeding could be withheld since the patient did not yet require tube feeding. The concurring opinion stated that the Court should await action from the legislature on that issue. An intermediate Appellate Court decision from Ohio looked to a recently enacted durable power of attorney statute which does not permit refusal of artificial feeding, and found that guardians were creations of the legislature, and should not have greater powers than appointed agents. *Couture v. Couture*, No. 11679 (Ohio Ct. App. Montgomery County Aug. 21, 1989).

[11] Arguments that tube feeding is "normal" or "basic" care, which must always be provided, have very little factual basis. Fearmongers who suggest that permitting the removal of tube feeding in isolated cases will lead to widescale abuse of the vulnerable elderly deliberately overstate the facts. Indeed, the very small number of nursing home patients who receive tube feeding is an indication of how unusual this form of treatment is. Available estimates are that 2%-5% of nursing home residents receive tube feeding. U.S. CONGRESS: OFFICE OF TECHNOLOGY ASSESSMENT, LIFE SUSTAINING TECHNOLOGIES AND THE ELDERLY 12 (1987). Data from the 1985 National Nursing Home Survey indicates that approximately 26,000 nursing home residents were tube fed (2% of the total nursing home population). Industry estimates were slightly higher: 53,400 (about 4%). U.S. CONGRESS: OFFICE OF TECHNOLOGY ASSESSMENT, LIFE SUSTAINING TECHNOLOGIES AND THE ELDERLY 297 (1987). Thus, somewhere between 26,000 and 54,000 nursing home residents are receiving tube feeding at any given time.

Through living will legislation, many states have addressed the question of artificial feeding. Ten statutes indicate that tube feeding can be withdrawn under certain circumstances.[12] Twelve statutes associate it with comfort care, and generally can be read as allowing patients to forgo artificially supplied sustenance if it is not necessary for comfort.[13] Fourteen statutes make no

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[12] Alaska Rights of Terminally Ill Act, Alaska Stat. § 18.12.010(c) (1986); Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, § 20-17-20(b) (Supp. 1987); Colorado Medical Treatment Decision Act, Colo. Rev. Stat. § 15-18-103(7) (1989); Idaho Natural Dealth Act, Idaho Code § 39-4504 (1985 & Supp. 1989); Illinois Living Will Act, Ill. Ann. Stat. ch. 110 1/2, § 702(d) (Smith-Hurd Supp. 1989); Minnesota Adult Health Care Decisions Act, S. 28, Chapter 145B, § 145B.03 (1989); Montana Living Will Act, Mont. Code Ann. § 50-9-202(2) (1987); North Dakota Act, H. 1481, Section 8(3), signed by Governor, April 12, 1989; Oregon Rights with Respect to Terminal Illness Act, Or. Rev. Stat. § 97.050(3) (1984); Tennessee Right to Natural Death Act, Tenn. Code Ann. § 32-11-103(5) (1988).

[13] Arizona Medical Treatment Decision Act, Ariz. Rev. Stat. Ann. § 36-3201(4) (1986); Florida Life-Prolonging Procedure Act, Fla. Stat. Ann. § 765.03(3) (1986); Hawaii Medical Treatment Decisions Act, Hawaii Rev. Stat. § 327D-2 (Supp. 1988); Indiana Living Wills and Life-Prolonging Procedures Act, Ind. Code Ann. § 16-8-11-4 (Burns Supp. 1989); Iowa Life-Sustaining Procedures Act, Iowa Code Ann. § 144A.2(5) (1989); Maryland Life-Sustaining Procedures Act, Md. Health-General Code Ann. § 5-605 (Supp. 1988); New Hampshire Terminal Care Document Act, N.H. Rev. Stat. Ann. § 137-H:2II (Supp. 1988); Oklahoma Natural Death Act, Okla. Stat. Ann. tit. 63, § 3102(4) (West Supp. 1989); South Carolina Death with Dignity Act, S.C. Code Ann. § 44-77-20(2) (Law. Co-op Supp. 1988); Utah Personal Choice and Living Will Act, Utah Code Ann. § 75-2-1103(6) (Supp. 1988); West Virginia

mention of artificial feeding thereby permitting interpretation so as to authorize its withdrawal consistent with medical ethics.[14] Of the five states whose statutes provide that artificial feeding is *not* a medical procedure which may be rejected under the statute, three have had supplemental case law vindicating the patient's common-law or constitutional right to forgo that treatment.[15]

Natural Death Act, W. Va. Code § 16-30-2(3) (1985); Wyoming Act, Wyo. Stat. § 33-22-101(iii) (1988). Oklahoma has a separate statute addressing the use of tube feeding. Hydration and Nutrition for Incompetent Patients Act, 63 Pub. Health & Safety § 3080 (West 1987).

[14] Alabama Natural Death Act, Ala. Code §§ 22-8A-1 to -10 (1984); California Natural Death Act, Cal. Health & Safety Code §§ 7185 to 7195 (West Supp. 1989); Delaware Death with Dignity Act, Del. Code Ann. tit. 16, §§ 2501 to 2509 (1983); District of Columbia Natural Death Act of 1981, D.C. Code Ann. §§ 6-2421 to -2430 (Supp. 1988); Kansas Natural Death Act, Kan. Stat. Ann. §§ 65-28,101 to -28,109 (1985); Louisiana Life-Sustaining Procedures Act, La. Rev. Stat. Ann. §§ 40:1299.58.1 to -.10 (West Supp. 1989); Mississippi Withdrawal of Life-Saving Mechanisms Act, Miss. Code Ann. §§ 41-41-101 to -121 (Supp. 1988); Nevada Withholding or Withdrawal of Life-Sustaining Procedures Act, Nev. Rev. Stat. §§ 449.540 to -.690 (1986 & Supp. 1988); New Mexico Right to Die Act, N.M. Stat. Ann. §§ 24-7-1 to -11 (1986); North Carolina Right to Natural Death Act, N.C. Gen. Stat. §§ 90-320 to -322 (1985); Texas Natural Death Act, Tex. Rev. Civ. Stat. Ann. art. 4590h (Vernon Supp. 1989); Vermont Terminal Care Document Act, Vt. Stat. Ann. tit. 18, §§ 5251-5262 (1987); Virginia Natural Death Act, Va. Code §§ 54.1-2981 to -2992 (1988); Washington Natural Death Act, Wash. Rev. Code Ann. §§ 70.122.010 to -.905 (Supp. 1989).

[15] Connecticut Removal of Life Support Systems Act, Conn. Gen. Stat. 19a-570(1) (Supp. 1989), as interpreted by *McConnell v. Beverly Enterprises*, 209 Conn. 692, 553 A.2d 596 (1989); Georgia Living Wills Act, Ga. Code Ann. § 31-32-2(5) (1985 & Supp. 1989), as supplemented by *In re Jane Doe*, No. D56730 (Super. Ct. Fulton County July 13, 1988); Maine Living Wills Act, Me. Rev. Stat. Ann. tit. 22, § 2921(4) (Supp. 1988), as supplemented by *In re Gardner*, 534 A.2d 947 (Me. 1987); Missouri Life Support Declarations Act, Mo. Ann. Stat. § 459.010(3) (Vernon Supp. 1989); Wisconsin Natural Death Act, Wisc. Stat. Ann. § 154.01(5) (West 1989).

State courts have gone to considerable lengths to interpret refusal of treatment statutes in a manner consistent with federal and state constitutional rights. The Connecticut experience exemplifies this interplay of judicial and legislative input. The Connecticut Supreme Court interpreted its Removal of Life Support Systems Act so as to provide "functional" guidelines for the exercise of the common law and constitutional rights of self-determination which have received almost universal recognition. *McConnell v. Beverly Enterprises*, 209 Conn. 692, 705, 553 A.2d 596, 603 (1989). The statutory definition of "life support systems" is "any mechanical or electronic device, *excluding the provision of nutrition or hydration*, utilized by any physician or licensed medical facility in order to replace, assist or supplement the function of any human vital organ or combination of organs and which prolongs the dying process." Conn. Gen. Stat. § 19a-570 (Supp. 1989) (emphasis added). Nonetheless, the Connecticut Supreme Court found that the right to refuse treatment, including tube feeding, was of constitutional dimension, and that the statute had been enacted to provide a means of its exercise. The Court stated that its Act, read in its entirety,

> implicitly contemplates the possible removal from a terminally ill patient of artificial technology in the form of a device such as a gastrostomy tube, but it does not under any circumstances, permit the withholding of normal nutritional aids such as a spoon or straw.

McConnell v. Beverly Enterprises, 209 Conn. 692, 705, 553 A.2d 596, 603 (1989). Thus, the Connecticut Court made what could be considered an expansive interpretation of the statute so as to find it consistent with a constitutionally protected right.

Similarly, the Court of Appeals in Florida, which has a statute associating artificial feeding with comfort care, held that although the legislation did not permit the re-

moval of artificial feeding, patients nonetheless retained their constitutional and common law rights to refuse that form of medical treatment. *Corbett v. D'Alessandro*, 487 So. 2d 368 (Fla. Dist. Ct. App.), *review denied*, 492 So. 2d 1331 (Fla. 1986); *In re Guardianship of Browning*, 543 So. 2d 258 (Fla. Dist. Ct. App.), *appeal filed*, Case No. 74,1747 (1989). The Court noted that the Act had a provision stating that it was supplemental to existing rights and law and that since the rights at issue were constitutional, they could not be limited by legislation. *Corbett v. D'Alessandro*, 487 So. 2d 368, 372 (Fla. Dist. Ct. App.), *review denied*, 492 So. 2d 1331 (Fla. 1986).

With like result, in 1987, courts in Colorado and Maine held that even if their state's living will acts did not authorize removal of a feeding tube, they too were cumulative with existing law and the right to refuse tube feeding is protected by either common law, *In re Gardner*, 534 A.2d 947 (Me. 1987), or constitutional law, *In re Rodas*, No. 86PR139 (Colo. Dist. Ct. Mesa County Jan. 22, 1987, *as modified*, April 3, 1987) (Buss, J.). Missouri is the only state to fail to heed the language of its own statute that the rights of the act are cumulative, and to find instead that its Living Will statute cut off any rights of patients to forgo treatment not enunciated in the Act. Mo. Ann. Stat. § 459.055 (Vernon Supp. 1987).[16]

The provision of artificial feeding against an individual's wishes can be extraordinarily intrusive and abusive treatment:

> The naso-gastric tube continues to pose significant hazards while it is in place. It may cause vomiting and aspiration of the gastric contents, producing a serious aspiration pneumonia. It may irritate the mucosal surfaces, causing bleeding, sometimes severe.

[16] Missouri's reliance on its Living Will statute to justify foreclosing rights is particularly ironic in Nancy Cruzan's case, since she had her accident before its passage.

> Many patients need to be restrained forcibly and their hands put into large mittens to prevent them from removing the tube, a thought which all patients with any degree of consciousness seem to have. These restrained patients may develop pneumonia and serious bedsores because of lack of activity and fixed positions.

Major, *The Medical Procedures for Providing Food and Water: Indications and Effects*, in BY NO EXTRAORDINARY MEANS (Lynn ed. 1986).

To carve out an exception to the individual's right to control treatment for this one form of medical care is more than an unreasonable burden on its exercise; in many cases, such as Nancy Cruzan's, it forbids its exercise. As noted above, in other circumstances, this form of treatment can be painful and degrading. Emotional arguments based on the symbolic importance of "food and water" which are at odds with national medical standards and can be violent intrusions on individual dignity do not meet "the compelling state interest" test. *Eisenstadt v. Baird*, 405 U.S. 438, 447 n. 7 (1972).

C. The Right to Have an Individualized Decision Should Not Be Burdened by Requiring Unrealistically Definitive Evidence of the Patient's Wishes to Forgo Life Support

The Missouri Supreme Court implied that to be effective, the evidence of an individual's wishes to forgo treatment must show that the patient made a precise and detailed decision to refuse life support under the very circumstances at issue. The result is that the Missouri Court glibly reasoned its way into banning the Cruzan family from any input into Nancy Cruzan's care. The evidentiary standards for the right to forgo treatment cannot be so "unduly burdensome" as to preclude its exercise. *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 453 (1983) (O'Connor, J., dissenting). A requirement of "clear and convincing" evidence

of the patient's previously informed personal choice will do just that.

Informed consent was developed as a doctrine to protect the liberty interest of competent people to *not* be treated without their informed permission. See, generally, Appelbaum, et al., *Informed Consent, Legal Theory and Clinical Practice* 35-63 (1987). As the Missouri Supreme Court itself noted, for incompetent patients, the same level of information is impossible: "[I]t is definitionally impossible for a person to make an informed decision—whether to consent or to refuse—under hypothetical circumstances." *Cruzan v. Harmon*, 760 S.W.2d 408, 418 (Mo. 1988), *cert. granted*, 109 S. Ct. 3240 (1989). To require such an impossible standard is to shift the burden so that all patients *must* receive treatment because they can never knowingly reject it in advance.

Some form of "substituted judgment" is the only workable standard which protects the patient's constitutional right to a decision: it is the "only practical way to prevent destruction of the right." *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976), *overruled in part, In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985). The substituted judgment doctrine "is intended to ensure that the surrogate decisionmaker effectuates as much as possible the decision that the incompetent patient would make if he or she were competent." *In re Jobes*, 108 N.J. 365, 414, 529 A.2d 434, 444 (1987). This approach allows a surrogate decisionmaker to decide the patient's course of care, taking into account everything known about the patient, including her personal value system, prior statements regarding medical conditions and situations, the patient's attitudes toward the impact of the medical condition on the family and loved ones, and any and all philosophical, theological and ethical beliefs which might be relevant. *Id.*, 108 N.J. at 415, 529 A.2d at 444.

Indeed, a substituted judgment allows an approximation of personal choice and its proper exercise could lead to a request for continued treatment, even against medical advice.

A substituted judgment that Nancy Cruzan would choose to forgo treatment does not make the exercise of the rights any less personal:

> [If the patient's] treatment is determined solely as a matter of medical technology [, her] life is prolonged because it is possible, not because anyone purporting to speak for [her] has decided that this is the best or the wisest course . . . [H]uman beings are not the passive subjects of medical technology . . . While [the patient's] coma precludes her participation, it is still possible for others to make a decision that reflects [her] interests more closely than would a purely technological decision to do whatever is possible. *Lacking the ability to decide, [she] has a right to a decision that takes [her] interests into account.*

Conservatorship of Drabick, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840, 854-855 (Cal. Ct. App. 1988), *review denied* (Cal. July 28, 1988), *cert denied*, 109 S. Ct. 399 (1988) (emphasis added). Under the Missouri Supreme Court's decision, it is not only medical technology which has dictated that Nancy Cruzan be treated, but it is also the State of Missouri, usurping the role of the family to speak for the patient.

The vast majority of state courts to have reached the issue have protected the constitutional rights of its citizens by endorsing family decisionmaking and the substituted judgment approach. *See, e.g. Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987); *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (Cal. Ct. App. 1988), *review denied* (Cal. July 28, 1988), *cert. denied*, 109 S. Ct. 399 (1988); *McConnell v. Beverly Enterprises*, 209 Conn. 692, 553 A.2d 596 (1989); *In re Severns*, 425 A.2d 156 (Del. Ch. 1980); *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*,

452 So. 2d 921 (Fla. 1984); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986); *In re Torres*, 357 N.W.2d 332 (Minn. 1984); *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983), *modified, In re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *In re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *In re Guardianship of Grant*, 109 Wash. 2d 545, 747 P.2d 445 (1987), *modified*, 757 P.2d 534 (1988).

Consistent with the constitutionally protected realm of family life outlined in Part I, it is those closest to the patient who should make the treatment decisions, not the state. Family members are usually the appropriate parties to make substituted judgment decisions because "[a]lmost invariably the patient's family has an intimate understanding of the patient's medical attitudes and general world view and therefore is in the best position to know the motives and considerations that would control the patient's medical decisions." *In re Jobes*, 108 N.J. 394, 415, 529 A.2d 434, 445 (1987). In this case, the Cruzans can speak for Nancy Cruzan and assert what they believe she would want, based on their lifetime experience with her, as well as her own clear statements on the issue.[17] They are guided by her specific conversations about the life support decisions she did encounter and are unanimous in their belief that Nancy would be appalled at her condition, and would choose to forgo the artificial feeding which merely sustains her existence.

Only New York and Maine, and in limited circumstances, New Jersey, have required that the patient's

[17] The trial court found Nancy Cruzan's statements to be clear and convincing evidence of her wishes. While in this case the patient provided the requisite level of evidence of her wishes, the substituted judgment standard is a more realistic approach in the majority of cases.

decision be demonstrated by clear and convincing evidence before the right to forgo life sustaining treatment can be exercised. Each of these courts specifically did so on common law grounds alone, implicitly recognizing the danger of cutting off constitutional rights by an unreasonably stringent evidentiary standard. *In re Gardner*, 534 A.2d 947, 952 (Me. 1987); *In re Westchester County Med. Center* (O'Connor), 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985). New York's clear and convincing standard particularly has been criticized for its overly restrictive consequences.[18]

[18] See, *In re Hier*, 18 Mass. App. 200, 464 N.E.2d 959 (Ct. App.), *review denied*, 392 Mass. 1102, 465 N.E.2d 261 (1984); *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840, 856-857, *review denied* (Cal. July 28, 1988), *cert. denied*, 109 S. Ct. 399 (1988); Rhoden, *Litigating Life and Death*, 102 Harv. L. Rev. 375, 390-91 (1988); Note, *A Patient's Last Rights—Termination of Medical Care—a Analysis of New York's In re Storar*, 46 Albany L. Rev. 1380 (1982); Note, *In re Storar, the Right to Die and Incompetent Patients*, 43 U. Pitt. L. Rev. 1087 (1982). As a dissenting New York Judge recently stated regarding New York's clear and convincing standard:

> In short, [the patient] expressed her wishes in the only terms familiar to her, and she expressed them as clearly as a lay person should be asked to express them. To require more is unrealistic and *for all practical purposes, it precludes the right of patients to forego life-sustaining treatment*. . . . Judges, the persons least qualified by training, experience or affinity to reject the patient's instructions, have overriden [the patient's] wishes, negated her long held values on life and death, and imposed on her and her family their ideas of what her best interests require.

In re Westchester County Med. Center (O'Connor), 72 N.Y.2d 517, 551, 534 N.Y.S.2d 886, 905, 531 N.E.2d 607, 626 (1988) (emphasis added). The restrictive nature of the clear and convincing evidence standard has the effect of either encouraging secretive decisionmaking in violation of the law, forcing clear-cut cases into court or mandating treatment for patients for whom it is medically inappropriate, but for whom evidence at the clear and convincing level is not available. New York Times, Nov. 13, 1988.

The governmental interest in protecting the vulnerable from abuse is not furthered by burdening medical decisionmaking with unmeetable and unreasonable standards. The fact that frequently there is nc written information or directly relevant oral information about patient preferences does not mean that a decision can be avoided: it means that the decision will invariably be to treat. Those incompetent patients who failed to leave a clear and convincing record of their wishes are not "protected" from bad decisionmaking by the presumption of continued treatment. The governmental interest in preventing abuse can be met by less restrictive means. Families or loved ones who do not act in good faith can be challenged, and those situations which are not resolved within the health care institution can be taken to court. See, generally, Meyers, *Medico-Legal Implications of Death and Dying*, 479-481 (1981). Decisions to treat should not be by default, because of a human failing to anticipate the precise details cf one's medical future. Substituted judgment allows decisions to withhold or withdraw life sustaining treatment to be made on an individual basis, consistent with the constitutional rights at stake.

CONCLUSION

For the foregoing reasons, we urge the Court to reverse the decision of the Missouri Supreme Court, and allow the Cruzan family to direct the medical care of Nancy Cruzan.

Respectfully submitted,

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